Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SUMMIT AMBULATORY SURGERY CENTER

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number
M4-13-1674-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MARCH 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Billed timely and pmt is due."

Amount in Dispute: $14,892.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Medicare Correct Coding Guide, (MUE) Medically Unlikely Edit lists the 'unit of practitioners limit' for the procedure code 63663 of one (1). Therefore, only one unit of CPT 63663 was paid."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 30, 2012	CPT Code 63688	$0.00	$0.00
	CPT Code 63663 (X2)	$14,892.21	$0.00
TOTAL		$14,892.21	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B13- Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 45- Charges exceed your contracted/ legislated fee arrangement.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.

- 193-No Code descriptor given.
- W1- Workers Compensation State Fee Schedule Adjustment
- U899-Procedure has exceeded the maximum allowed units of service.

Issues

1. Did the requestor support billing two (2) units of code 63663?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for two units of CPT code 63663 rendered on October 30, 2012.

   CPT Code 63650 is defined as "Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed."

   The respondent contends that additional reimbursement is not due because "The Medicare Correct Coding Guide, (MUE) Medically Unlikely Edit lists the 'unit of practitioners limit' for the procedure code 63663 of one (1)."

   Based upon the code descriptor, regardless of the number of array(s) that are replaced, only one unit is reimbursable per encounter.

2. 28 Texas Administrative Code §134.402(f)(2)(A)(i)(ii) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (2) Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent."

   28 Texas Administrative Code §134.402(f)(2)(A)(i)(ii) reimbursement for device intensive procedure code 63633 is a two step process:

   Step 1 calculating the device portion of the procedure:

   The national reimbursement is found in the Addendum B for National Hospital Outpatient Prospective Payment System (OPPS) code 63633 for CY 2012 = $4,460.40.

   This number multiplied by the device dependent APC offset percentage found in the Addendum B for National Hospital OPPS reimbursement of 55% = $2,453.22.

   Step 2 calculating the service portion of the procedure:

   The Medicare fully implemented ASC reimbursement rate is $3,593.57.

   The City Wage Index for Houston, Texas is 0.9945.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $3,583.67.

   The service portion is found by taking the national adjusted rate of $3,583.67 minus the device portion of $2,453.22 = $1,130.45.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $1,130.45 X 235% = $2,656.55.

   The MAR is determined by adding the sum of the reimbursement for the device portion of $2,453.22 + the geographically adjusted service portion of $2,656.55 = $5,109.77. The insurance carrier paid $5,186.93. As a result, $0.00 is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		08/08/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.